DATE (YYYY / MM / DD)	CLIENT'S FAMILY NAME	CLIENT NUMBER

D. DENTAL CARE

1. DOES CLIENT CURRENTLY HAVE DENTAL PROBLEMS? ☐ YES ☐ NO
2. IS CLIENT UNDER CARE OF DENTIST? ☐ YES ☐ NO
4. IS CLIENT ABLE TO CHEW FOOD EFFICIENTLY? ☐ YES ☐ NO

3. DENTAL STATE
1. ☐ NO DENTURES
2. ☐ FULL UPPER
3. ☐ FULL LOWER
4. ☐ PARTIAL DENTURE
5. ☐ DAMAGED DENTURES
6. ☐ NO DENTURES, NO TEETH
7. ☐ DENTURES NOT WORN

5. DENTIST'S NAME

E. COMMUNICATON

1. ☐ WEARS GLASSES **2. ☐ USES HEARING AID**

LANGUAGES USED
- ☐ ENGLISH
- ☐ FRENCH
- ☐ CHINESE
- ☐ ITALIAN
- ☐ RUSSIAN
- ☐ OTHER

1. VISION
1. ☐ UNIMPAIRED
2. ☐ ADEQUATE FOR PERSONAL SAFETY
3. ☐ DISTINGUISHES ONLY LIGHT OR DARK
4. ☐ BLIND - SAFE IN FAMILIAR LOCALE
5. ☐ BLIND - REQUIRES ASSISTANCE

2. HEARING
1. ☐ UNIMPAIRED
2. ☐ MILD IMPAIRMENT
3. ☐ MODERATE IMPAIRMENT - ADEQUATE FOR SAFETY
4. ☐ IMPAIRED - INADEQUATE FOR SAFETY
5. ☐ TOTALLY DEAF

3. SPEECH
1. ☐ UNIMPAIRED
2. ☐ SIMPLE PHRASES INTELLIGIBLE ONLY
3. ☐ SIMPLE PHRASES PARTIALLY INTELLIGIBLE ONLY
4. ☐ ISOLATED WORDS INTELLIGIBLE ONLY
5. ☐ NO SPEECH/NOT UNDERSTANDABLE/NO SENSE MADE

4. UNDERSTANDING
1. ☐ UNIMPAIRED
2. ☐ UNDERSTANDS SIMPLE PHRASES ONLY
3. ☐ UNDERSTANDS KEY WORDS ONLY
4. ☐ UNDERSTANDING UNKNOWN
5. ☐ NOT RESPONSIVE

5. METHOD OF COMMUNICATING
IF CLIENT CANNOT SPEAK, INDICATE MEANS AND DEGREE OR EFFECTIVENESS OF METHOD
1. ☐ EFFECTIVE
2. ☐ MODERATELY EFFECTIVE
3. ☐ PARTIALLY EFFECTIVE
4. ☐ NOT EFFECTIVE

6. ADDITIONAL COMMENTS ON COMMUNICATION

F. ACTIVITIES OF DAILY LIVING

1. ☐ USES CANE
2. ☐ USES WALKER
3. ☐ USES CRUTCHES
4. ☐ USES WHEELCHAIR
5. ☐ OTHER PROSTHESIS OR AID

1. AMBULATION
1. ☐ INDEPENDENT IN NORMAL ENVIRONMENTS
2. ☐ INDEPENDENT ONLY IN ENVIRONMENT BELOW
3. ☐ REQUIRES SUPERVISION
4. ☐ REQUIRES OCCASIONAL OR MINOR ASSISTANCE
5. ☐ REQUIRES SIGNIFICANT OR CONTINUED ASSISTANCE

SPECIFY LIMITATIONS IN ADDITIONAL COMMENTS BELOW.

2. TRANSFER
1. ☐ INDEPENDENT
2. ☐ SUPERVISION FOR: ☐ BED ☐ CHAIR ☐ TOILET
3. ☐ INTERMITTENT ASSISTANCE ☐ BED ☐ CHAIR ☐ TOILET
4. ☐ CONTINUED ASSISTANCE ☐ BED ☐ CHAIR ☐ TOILET
5. ☐ COMPLETELY DEPENDENT FOR ALL MOVEMENT

3. BATHING
1. ☐ INDEPENDENT IN BATH OR SHOWER
2. ☐ INDEPENDENT WITH MECHANICAL AIDS
3. ☐ MINOR ASSISTANCE OR SUPERVISON
4. ☐ CONTINUED ASSISTANCE
5. ☐ RESISTS

4. DRESSING
1. ☐ INDEPENDENT
2. ☐ SUPERVISION AND/OR CHOOSING OF CLOTHING
3. ☐ PERIODIC OR DAILY PARTIAL HELP
4. ☐ MUST BE DRESSED
5. ☐ RESISTS

5. GROOMING/HYGIENE
1. ☐ INDEPENDENT
2. ☐ REMINDER, MOTIVATION AND/OR DIRECTION
3. ☐ ASSISTANCE WITH SOME ITEMS
4. ☐ TOTAL ASSISTANCE
5. ☐ RESISTS

6. EATING
1. ☐ INDEPENDENT
2. ☐ INDEPENDENT - SPECIAL PROVISION; DISABILITY
3. ☐ INTERMITTENT HELP
4. ☐ MUST BE FED
5. ☐ RESISTS

7. BLADDER CONTROL
1. ☐ TOTALLY CONTINENT
2. ☐ ROUTINE TOILETING OR REMINDER
3. ☐ INCONTINENCE DUE TO IDENTIFIABLE FACTORS
4. ☐ INCONTINENT - LESS THAN ONCE PER DAY
5. ☐ INCONTINENT - MORE THAN ONCE PER DAY

8. BOWEL CONTROL
1. ☐ TOTALLY CONTINENT
2. ☐ ROUTINE TOILETING OR REMINDER
3. ☐ INCONTINENCE DUE TO IDENTIFIABLE FACTORS
4. ☐ INCONTINENT - LESS THAN ONCE PER DAY
5. ☐ INCONTINENT - MORE THAN ONCE PER DAY

9. ADDITIONAL COMMENTS ON ACTIVITIES. NOTE FREQUENCY OF MOST PROMINENT PROBLEMS. COMMENT ON SIGNIFICANT SLEEP PATTERNS.

GENERAL INSTRUCTION

Enter client's family name and client number to identify this page when detached.

IID DENTAL CARE

IID1 Consider current problems, such as periodontal disease, bleeding gums and/or pain, badly decayed teeth and any other lesions in the mouth.

IID2 If the answer is yes, indicate dentist's name in IID5.

IID3 Indicate dental state. Multiple responses are valid.

IID4 Establish if client is able to chew normal or solid food with or without dentures.

IIE COMMUNICATION

IIE1 VISION

BLOCK 2: Person has sufficient vision to move about safely in care environment and can recognize the fire exit routes.

BLOCK 3: Person has insufficient vision to move about safely in care environment. Consider any other apsects, such as mental confusion.

BLOCK 4: Although person is blind, they can function routinely in familiar locale, even though assistance required to find exit routes in emergency.

BLOCK 5: Person requires assistance in normal functions as well as emergency situation.

IIE2 HEARING

BLOCKS 3 & 4: Criteria is whether person can hear fire alarm or shouted alarm.

IIE3 SPEECH

Indicate functional ability and amplify in IIE6 if necessary.

IIE4 UNDERSTANDING

Enlarge on problem in IIE6 if necessary.

IIE5 ALTERNATE MEANS OF COMMUNICATION

Complete only if applicable. Indicate alternate means (e.g. lip reading, sign language).

IIF ACTIVITIES OF DAILY LIVING

Indicate prosthesis and aids used, in coded blocks.

IIF1 AMBULATION

BLOCK 1: This refers to the usual environment of a healthy person with full functions in the applicable age group.

BLOCK 2: A person may be only independent within their own home or care facility. Specify limitation.

BLOCK 3: Client may be unsteady or need supervision for other factors. Specify limitation.

BLOCK 4: Client cannot proceed beyond certain point without assistance, but can be left unattended after that point.

BLOCK 5: Client requires continued complete attention of assisting person.

Ensure particular limitations of client are outlined. Indicate tolerance to activity - up all day, for one hour, etc.

IIF2 TRANSFER

Indicate wheelchair in "chair".

Distinction between Block 4 and Block 5 is whether continued attention of staff is required. Assistance means "hands-on" help.

IIF3 BATHING

BLOCK 1: Cross out non-applicable word if entry in this block.

BLOCK 3: Assistance in and/or out of the bath.

BLOCK 4: Must be bathed; sponge or bath.

IIF4 DRESSING

BLOCKS 2 & 3: Cross out non-applicable words.

IIF5 GROOMING/HYGIENE

BLOCK 3: Specify items in "Comments".

IIF6 EATING

See also IID4.

BLOCK 2: Specify special provision (e.g. blind place setting) in IIF9.

BLOCK 3: e.g. placing spoon in hand, cutting meat.

BLOCK 4: See also IIB4-3.

IIF7 BLADDER

BLOCK 3: Incontinence due to specific factors such as use of diuretics, stress incontinence, distance from toilet, etc. Specify in IIF9.

BLOCK 4: Consider average situation. Specify frequency, day/night in IIF9.

BLOCK 5: Consider average situation, but specify gross problem in IIF9.

IIF7 BLADDER

BLOCK 3: Incontinence due to use of laxatives, suppositories, etc.